Hamilton Niagara Haldimand Brant
LOCAL HEALTH INTEGRATION NETWORK
RÉSEAU LOCAL D'INTÉGRATION DES SERVICES DE SANTÉ
de Hamilton Niagara Haldimand Brant

Quality Care in Community Hands: Building an Integrated Health Service Plan Phase One

Hamilton Niagara Haldimand Brant
Local Health Integration Network

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Acknowledgments ii

Introduction 1
Local Health Integration Networks 1
The Context for Change 1

The Integrated Health Service Plan 3
Our Local Vision 3
Supporting and Sustaining Solution Building 3
Listening and Learning: Issues and Opportunities for Integrated Health Service Planning 3

Community Profile 5

Priorities and Progress for Health System Improvement 8
Local Health Integration Services Priorities 8
MOHLTC Priorities 15
Emerging Priorities for Change 25

Looking Ahead 27
Setting the Stage: Achievements in the LHIN 27
Current Activities 2006-2007 28
Summary Action Plan 29

End Notes

Appendices:

A. Our Commitment to You: Community Engagement For Health Care Planning & Decision Making. March 2006
B. Quality Care in Community Hands.We're Listening. Summary Report on Community Open Houses 2006. August 2006
C. Local Health Integration Service Priorities: Opportunities for Change. Executive Summaries. August 2006
D. Opportunities for Health System Improvement. Open Consultation. September 2006
E. e-Health Strategic Plan. Focusing on the Future: Creating Connections to Improve Health Care. October 2006
F. Hamilton Niagara Haldimand Brant e-Health Strategic Plan Executive Summary. October 2006
G. Health Human Resources: Planning for an Aging Population. October 2006
H. Hamilton Niagara Haldimand Brant LHIN Community Profile. August 2006.

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The Ministry of Health and Long-Term Care (MOHLTC) has embarked on a bold health transformation agenda. This agenda is designed to improve access to health services for all Ontarians and ensure the right care at the right time in the right place.

A key feature of this transformation is the creation of Local Health Integration Networks[1] (LHINs) that will bring health care decision making and funding to communities where health services are planned, organized and delivered. An early responsibility of LHINs is the facilitation of activities for improved health services delivery in their area. This first Integrated Health Service Plan (IHSP) sets the stage for a three-year planning cycle to develop a comprehensive directional plan to achieve Ontario's health goals locally.

This Plan outlines the current work of the Hamilton Niagara Haldimand Brant LHIN and a planning and coordination agenda for Year 2. It describes what we have learned about our communities, early strategies for health system improvement, and our initiatives over the next several months.

The Ministry of Health and Long-Term Care has created 14 LHINs across the province to plan, coordinate and fund local health care based on community need. LHINs have the responsibility to work with citizens, stakeholders and providers to enhance services as close to home as possible. This service envelope includes community support services, community health centres, community care access centres, mental health and addictions services, long-term care homes, and hospitals. Overall, LHINs will oversee nearly two-thirds of the health care budget in Ontario.

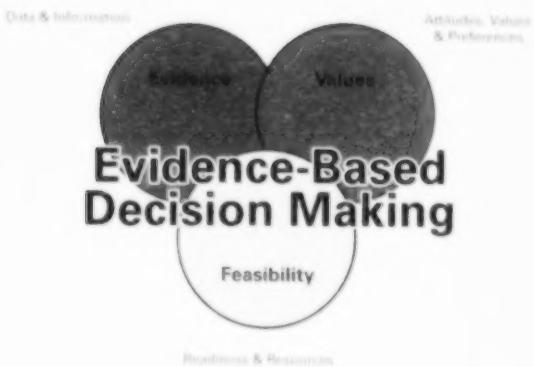
Each LHIN is governed by a nine-member Board of Directors appointed by the province from among members of the LHIN's communities. The Board will make balanced decisions about health services based on the values of communities, a sound understanding of the issues and resources, and knowledge as to what practices, models and approaches have a positive impact.

LHINs' roles are evolving. Many of the regulations emanating from the legislation are in progress. These regulations[2] will shape how LHINs approach their work within their organization, for example, Board committee structure, and in their communities, for instance with French language and aboriginal populations. While funding responsibility is anticipated in Spring 2007, LHINs will make funding decisions for health service provider organizations for the 2008-2009 fiscal year.

The Context for Change

Citizens, stakeholders and health providers have long asserted the need for a sustainable, responsive, and flexible health system, one that inspires confidence in communities and providers for future generations. The Government of Ontario announced a Health Transformation Plan[3] in 2004 with the following goals:

- A system that is better integrated and easier for patients to navigate.
- Reduced wait times for cardiac care, cancer care, hip and knee replacement, cataract surgery, and diagnostic imaging.



- Better access to comprehensive, round-the-clock care to people in their own communities.

- Expanded access to home care and long-term care to free up hospitals and speed up treatment.

A principal tenet of health reform in Ontario is that people who live and work in a LHIN are best able to determine their health care needs and priorities, and make decisions about the allocation of resources in their area. Unlike regional health authorities elsewhere in Canada, Ontario LHINs are not service providers and Governing Boards of provider agencies remain in place. The Ontario Government respects the role of volunteer governance and local knowledge, insight and experience for guiding health services.

The role of Local Health Integration Networks in Ontario is fourfold[1]:

- Manage health delivery system planning, coordination and funding at the local level.

- Engage the community in local health system planning and priority setting, including establishing formal channels for citizen input and community consultation.

- Improve the accessibility of health services to allow people to move more easily through the health system.

- Bring economic efficiencies to the delivery of health services, promoting service innovation, improving quality of care, and making the health care system more sustainable and accountable.

The implementation of LHINs is not without challenges. Broad citizen engagement in planning and decision making is challenging when people most often care about the health system when they need services; it can be difficult to capture their interest at other times. Not all health service provider Boards and organizations have the skills and resources to meet their new responsibilities, or the challenges for aligning competing interests. Local decision making will require sound integration of information about community values, evidence for issues and solutions, and assessment of available resources. Provider accountability agreements will be available for public scrutiny; this raises the need for "plain speak" to support transparency and public participation in discussions on the health system.

These new ways of work for shared responsibility will require the assembly of tools and approaches to support citizens, stakeholders and providers to forge positive relationships for health system change.

This first Integrated Health Service Plan (IHSP) describes initial priorities and activities for the three-year period beginning Fall 200€. The ministry's 10-year strategic plan for the Ontario health system, expected in Spring 2007, will also guide and inform LHIN priorities over time.

The Hamilton Niagara Haldimand Brant LHIN approach to the IHSP is consistent with MOHLTC expectations of LHINs in the development of the IHSP in Year One[5]. This Plan summarizes strategies that address local priorities described in February 2005[6], progress on current MOHLTC priorities, a readiness assessment for selected activities, and the LHIN's work plan over the next several months.

Our Local Vision

In September 2004, the Ontario Minister of Health and Long-Term Care launched the Health Transformation Agenda and announced the ministry's vision for a sustainable health system.

The Hamilton Niagara Haldimand Brant LHIN has adopted this vision. Consistent with the tenets of Ontario's health reform – local decision making and shared responsibility for health system outcomes – the LHIN is committed to achieving quality care in our communities and planning the future health system together with citizens, stakeholders and providers.

Supporting and Sustaining Solution Building

LHINs are somewhat like community support organizations[7] whose principal role is to facilitate successful health system change. To this end, the Hamilton Niagara Haldimand Brant LHIN will foster the success of local collaborations to improve the way we solve problems. We are building our capacity to convene and engage conversations, strengthen broad community involvement in planning and decision making, involve leaders of existing and emerging collaborations, and sustain regular and clear communication.

Listening and Learning: Issues and Opportunities for Integrated Health Service Planning

The HNHB LHIN continues to listen and learn. Relationship building commenced with the appointment of three board members in June 2005 and continues still. The Chair, Board members, CEO and Staff have had approximately 300 meetings with community groups, stakeholders and providers, introducing the LHIN and learning about the range of issues and expectations of others for change.

The LHIN held 14 open houses in late Spring and Summer 2006 (including one in September); these were the formal introduction of LHIN Board Members and staff to the community. More importantly, the sessions provided an opportunity to ask people what is important to them about their health system, what changes would they make and what is important for the LHIN to know about their communities.

In addition, the HNHB LHIN leadership met with approximately 400 health service provider (HSP) Board members and executive leadership in five forums in September 2006. The forums provided an opportunity to review the expectations related to accountability in the Local Health System Integration Act for the LHIN organization and HSPs, mutual expectations, and new ways of work.

Discussions with academic health science partners, community health centres, the French language community, the Aboriginal community and elected decision makers have helped the LHIN organization develop early relationships with our key publics. These dialogues have uncovered key issues – both opportunities and challenges – for achieving an improved health system in the LHIN. The outcomes are confirming the LHIN's responsibility to help build the capacity of all stakeholders to work together differently to facilitate change.

The Hamilton Niagara Haldimand Brant LHIN understands that:

- Readiness for change and health improvement is high; enthusiasm will be sustained with evidence of real change supported and implemented where feasible.

- Generally, there is an emerging confidence that the LHIN organization will support and implement evidence based solutions for change and facilitate enhanced accountability among all health providers.

- Health is a community asset. Available and quality health care services are important to the viability of communities. Communities and their decision makers, foundations, and volunteers are proud of their longstanding contributions to health care services and have a strong interest in their local health system.

- Community members want to trust their decision makers. While credibility is earned, personal contact between LHIN Board members and people who live and work in LHIN communities has been important and is raising people's interest in local decision making.

- There is concern among some communities that they will be "orphaned" in the LHIN; communities of interest, geographic communities, and special population groups are concerned that their needs and aspirations will not be heard.

- The LHIN is a microcosm of the province. Its geography, population, political and industrial profile, distribution of wealth and health status are variable across communities. Some LHIN-wide indicators have a considerable range when analyzed at the sub-LHIN level. Decision making will need to consider how to ensure access to health services and quality outcomes for all HNHB LHIN residents and others who appropriately use specialized services in our LHIN.

- Many factors influence access to services. Criteria for accessibility include, for example, the extent to which services are known, available in a timely way, sensitive to the needs and values of communities, and responsive to language, cultural and ethno-specific diversities, physical capacity including sight and hearing capacity, distance traveled, and any associated cost burdens.

- Partnerships for collaboration are required among all health care sectors. The LHIN does not have planning and funding responsibility for public health, physicians (OHIP), pharmacy, ambulance services, independent health facilities, and capital resources. At the same time, effective alignment of all health care resources for shared

goals – right service, right time, and right place is key. For instance, chronic disease management initiatives are underway among public health units, family health teams and community health centres. Coordinated strategies will serve the public interest.

- Health status is influenced by access to health care. However, other factors, commonly referred to as the "determinants of health" contribute to the health and well-being of individuals and communities, particularly personal health practices and coping skills, along with education, employment, income, and the availability of housing, food and social support. The LHIN has a responsibility to work collaboratively within health care and across other sectors, such as education, housing, transportation, etc., to help communities overcome obstacles to improving population health status.

- Relationships are the new accountability. No one person, stakeholder, or provider organization is alone responsible for health system improvement.

Citizens, stakeholders and providers have been clear about their expectations of LHIN leadership. The LHIN is encouraged to respect diversity, acknowledge the range of supports that organizations need to participate in the health transformation agenda, and to facilitate forums for exchange of ideas and opportunities. LHIN leadership is encouraged to dispel misinformation about the LHIN agenda, promote system-wide solutions, and acknowledge and credit success. Our publics are looking to the LHIN to facilitate change for "health delivery that is informed, balanced and progressive". Finally, the LHIN is encouraged to adopt population health planning approaches that will integrate the broad determinants of health in planning activities and identify strategies that will improve health outcomes and reduce differences, or inequities, among population groups.

Community Characteristics

The Hamilton Niagara Haldimand Brant LHIN stretches from Fort Erie to Turkey Point and Paris to Lowville and covers approximately 7,000 square kilometres. It encompasses Brant, Burlington, Haldimand, Hamilton, Niagara and Norfolk, each having a rich history of local identification and sense of community despite the fact there have been numerous boundary changes over the past three decades.

The Regional Municipality of Niagara encompasses 12 municipalities, and the City of Hamilton incorporates 6 former municipalities. The Counties of Norfolk and Haldimand were united in 1974 and then separated again in 2001. Brant area, including the City of Brantford and the City of County of Brant, underwent additional boundary revisions in 2005. Burlington, part of the Regional Municipality of Halton, is considered part of the Greater Toronto Area (GTA).

The LHIN has wide variations in population density. It includes both urban and rural land areas. While Haldimand and Norfolk have the greatest percentage of rural settlement, all communities in the LHIN include rural areas.

Both Hamilton and Niagara are designated communities for French language services, as more than 5,000 people in each area identify French as their mother tongue. Hamilton is one of the main ports of entry for new immigrants into Canada; approximately 25% of the City's population are immigrants. Niagara, with its close proximity to the United

States border, is a major receiver of refugees, whose numbers are not likely to be captured through Census enumeration. There are also seasonal migrant workers who are not included in official population statistics; they locate in the Niagara, Haldimand and Norfolk areas for temporary agricultural and tourism employment.

Aboriginal status is also a marker of potential health care needs. The Aboriginal population has lower incomes, lower life expectancy and higher rates of illness, compared to the average Canadian. There are two reserves in the LHIN: Six Nations of the Grand River Territory and Mississaugas of the New Credit First Nation. Approximately half of the aboriginal population residing in the LHIN area live On-reserve. As of August 2006 the total registered Aboriginal population living On or Off-reserve in the LHIN was 24,263, or 1.7% of the total LHIN population. Population data for non-status, Métis, and Inuit aboriginal populations are not precise; people are mobile, homelessness is high, and some Aboriginal persons choose not to self identify.

On average, men and women in our LHIN live shorter lives; life expectancy at birth is significantly lower than life expectancy for Ontario. Infant mortality, a predictor of child health and well being of society as a whole, is similar to the provincial average.

In general, the population is aging in all HNHB LHIN communities and this is expected to produce greater demands on the health system. The HNHB LHIN has an older age structure with 15.1% of the population age 65 years and older when compared to the province (at 12.8%). Within the LHIN, Niagara and Norfolk have a higher proportion of seniors at 16.9% and 16.5% respectively. Niagara has the greatest percentage of seniors age 75+ years in Ontario.

The incidence of low income in the LHIN is less than the Provincial average. Low income is associated with increased morbidity, premature deaths, and higher utilization of services. Hamilton, Brantford and Port Colborne have a higher incidence of low income within the LHIN. In Hamilton, one in five residents is living in poverty and the community's Poverty Roundtable is addressing this problem. Burlington is more affluent than other areas in the LHIN and its inclusion in statistical calculations inflates the LHIN's median income.

Self reported "poor" or "fair" health in Brant, Haldimand, Hamilton and Norfolk is higher than the provincial average. Poorer self reported health is associated with greater use of health services. The percentage of residents reporting activity limitations requiring assistance is also greater than the provincial average in all HNHB LHIN communities, with the exception of Burlington.

Our LHIN has a higher prevalence of arthritis/rheumatism and higher rates of other chronic conditions, including high blood pressure and heart disease, when compared to the rest of Ontario. Chronic conditions place a high burden on the health care system and reduce quality of life for those persons affected.

Residents in the HNHB LHIN are generally more overweight and obese; have a higher rate of exposure to secondhand smoke in the home and consume more alcohol. Poor health practices increase the risk of chronic disease and disability. On a positive note, residents are less likely to report life stress than the rest of Ontario.

Preventive health care services can lead to early detection. On selected health practices – flu shot, mammogram and pap smear – practices in the LHIN are similar to Ontario as a whole.

Health System Characteristics

The shortage of family physicians and specialists is a concern in all communities in the HNHB LHIN. The point of access for most medical care is through a primary care physician and they play a key role in coordinating care and managing chronic conditions. All areas are currently designated under-serviced for family physicians with the exception of Hamilton. However, the physician per population benchmark[9] does not take into account service delivery levels, and many Hamilton area physicians have teaching responsibilities and/or work part time.

There are 248 health service provider agencies in the Hamilton Niagara Haldimand Brant LHIN, delivering a wide range of health services. Five Community Care Access Centres (CCACs) hold service agreements with approximately 60 provider organizations.

Community Support Services	91
Mental Health	29
Substance Abuse	14
Problem Gambling	4
Community Care Access Centres	5
Long Term Care Homes	90
Hospitals (Corporations)	12
Community Health Centres	3

Most people get most of their health care most of the time in the community (not in hospitals), and most residents get most of their hospital-based care in the LHIN. Total outflow for inpatient hospital care in 2005 was about 10,000 cases, representing just over 7% of all inpatient hospital care received by residents of the LHIN. Reasons for going outside the LHIN include the need to access a highly specialized service, close proximity to another LHIN, residents using services closer to work or family, or, as a result of provincial wait list management for timely care. Obstetrics, general surgery, psychiatry and cardiac care account for 50% of inpatient hospital care received by residents outside the LHIN.

There are 12 hospital corporations (and 23 hospital sites) in the HNHB LHIN. The hospitals in Hamilton are teaching hospitals with tertiary care responsibilities for a large regional catchment area. In 2005, approximately one-third of inpatient hospitalizations at Hamilton hospitals were for non-Hamilton residents. About one-third of these inpatient cases (5,400) came from outside the LHIN area.

The HNHB LHIN is home to the Faculty of Health Sciences, McMaster University in Hamilton, one of six medical schools in Ontario. Two Academic Health Science Centres (AHSCs) in Hamilton – Hamilton Health Sciences and St. Joseph's Healthcare (also referred to as teaching hospitals) – are characterized by their mission of clinical service, education and research.

The academic health care environment is critical to a quality health system – one that integrates services, education and training, and research for best outcomes and sustainability. It is where the most complex patients receive care and where significant research is being conducted. It is an essential resource for the education and training of future health care professionals. The academic environment is also uniquely important as one in which new technologies are being developed and diffused and where "system"

change can be modeled. The success of integrating academic expertise to strengthen the local health system will be based upon their effective involvement and participation; the involvement of the many interest groups, partners and stakeholders within this environment; and the ability to build relationships between academic hospitals and other hospitals and community providers which increasingly play a role in health human resource education[10].

Health System Performance

The Health Results Team of the Ministry of Health and Long-Term Care has produced a set of preliminary planning indicators to inform the ministry's strategic plan, expected in Spring 2007. Indicators are designed to measure progress in achieving health reform goals aligned with expectations for better access to health services, coordinated health care and effective and efficient health system management at the local level. In future, the data will allow for tracking progress over time and making comparisons across LHINs for the purposes of identifying best practice among comparable LHINs.

The data indicate how the Hamilton Niagara Haldimand Brant LHIN compares to trends in other LHINs. The HNHB LHIN compares favourably, for instance, in the application of clinical practice guidelines for care, and satisfaction with the health services. There is room to improve access to community-based services to reduce admissions to emergency departments and inappropriate hospitalizations, to support end-of-life care in the community, and to address unmet need.

Local Health Integration Service Priorities

Initial priorities for health system improvement were identified in all LHINs in Fall 2004/ January 2005. The MOHLTC held 14 open space consultation sessions in each of the pending LHIN regions and invited local community stakeholders to identify integration priorities for their area.

Community stakeholders and providers from Brant, Burlington, Haldimand, Hamilton, Niagara and Norfolk identified priorities in November 2004. Approximately 400 people participated in a one-day session and deliberated on approximately 55 issues and opportunities for health system improvement. The outcome was 10 initial priorities to improve consumers' experiences in the health system. These were described by a Steering Committee in a report to the MOHLTC in February 2005.

The Steering Committee for Hamilton Niagara Haldimand Brant Local Health Integration Network Priorities was invited by the LHIN Chair and CEO to build on the momentum for change and identify planning or implementation strategies for the priorities. The champions for each of the service priority areas have worked with their networks and communities of interest to identify opportunities for positive change across the LHIN. The LHIN organization, in partnership with others, is facilitating the development of approaches to the administrative/enabling priorities identified.

Generally, there is strong support for the strategies on the initial integration priorities. Not surprisingly, communities look forward to broader system change strategies, and continue to emphasize the importance of client and patient focus, inclusion of primary care physicians in planning care strategies, and sensitivity to the needs of marginalized populations.

Health Promotion and Prevention

A health collaborative will bring together stakeholders from the Workplace Safety and Insurance Board (WSIB), the Department of Family Medicine at McMaster University, and Occupational Health Clinics for Ontario Workers, and family physicians, public health departments, business and consumers. It will:

- Identify the resources, practices and costs related to occupational health and disease.
- Identify and implement strategies to address improvement opportunities for effective use of resources and health outcomes.

Expected Outcomes

- Evaluate the potential for health improvement opportunities to achieve desired outcomes i.e. reduction of workplace related illness and injury.
- Understanding and identification of workplace illness and injury by physicians and other primary care professionals.
- Improved health outcomes for people with workplace illness and injury.

Coordinate Services for Children and Youth

McMaster Children's Hospital is committing resources for one year to work with agency program and service staff across the LHIN and identify their needs for education and training that will help them work with their clients. This will lead to the development of relevant education and training programs.

Expected Outcomes

- Improved access to child and youth specialized assessment and treatment services, closer to home.
- Consistent level of evidence-based mental health services in communities.
- Improved mental health outcomes.
- Proportionately higher number of assessments and treatment being done by local community-based programs/services.
- Identification and application of best practices in community-based programs.
- Standardization of assessments and treatment approaches in the LHIN.
- Reduction in wait times for psychiatric treatment.
- Reduced need for hospital admissions for children/adolescent psychiatric issues.

The network will bring together rehab service providers including: hospitals, Community Care Access Centres (CCAC) and Children's Treatment Centres (CTCs). Initially, the Network will be an information-sharing forum and will examine the potential for common education programs to expand best practice across the LHIN. McMaster Children's Hospital will facilitate the development of the Network.

Expected Outcomes

- Faster access to specialized pediatric rehabilitation.
- Consistent level of evidence-based rehabilitation services across the region.

- Quicker reintegration into activities of daily living for children and young people.
- Improved coordination of services among hospitals, Children's Treatment Centres, Community Care Access Centres and local providers.
- Identification and implementation of evidence-based practices.

The Child Health Knowledge Exchange will develop and offer consistent and collaborative education and training events for child health professionals across the LHIN. It will also provide an opportunity for peer review and personal development.

Expected Outcomes

- Application of evidence-based services across the LHIN.
- Improved access to diagnostic and treatment processes for children and young people.
- Increased identification and application of evidence-based practices.
- Increased knowledge of and communication between acute care and community-based child health care providers.

McMaster Children's Hospital will lead the launch and implementation of the Electronic Child Health Network, including the Health Information Network to support the graduated sharing of child and youth health records with hospitals, physicians and community based service providers to support timely care response and follow up.

Expected Outcomes

- Share information between providers to reduce unnecessary tests or diagnostic procedures.
- Facilitate consistent level of evidence-based services across the LHIN communities.
- Improve health outcomes for children and young people through improved access to information.
- Reduce duplicate tests or diagnostic procedures.
- Improve communication between regional and local providers.
- Increase knowledge and utilization of evidence-based practices.

Assist Persons to Live Independently in the Community

Selected community support services and other providers will develop care paths for three identified population groups and describe a comprehensive mix of services for patient care and recovery. Persons recovering from hospital-based services or receiving care in the community can benefit from supports that maximize recovery and/or prevent or delay hospitalization.

Expected Outcomes

- The right mix of services are documented to ensure a continuum of care.
- Collaboration among providers to ensure smooth transitions between health service providers.
- Informed patients/clients about the course of care.
- Increased patient satisfaction.

Support Persons with Mental Health and Addiction Issues

Services will work together to:

- Share program successes, strengths and solutions.
- Promote best practices and standards of care.
- Develop a LHIN-wide plan for cross-training of staff and cross-sector staff secondments.
- Investigate the feasibility of inter-agency service delivery teams and/or co-location of services in one location.
- Develop protocols for increased service collaboration and shared care between mental health and addiction programs.

Initiatives will build on existing work in the Central South Mental Health Implementation Task Force Report (2002). Processes and outcomes will be shared at regional and area mental health and addiction networks.

Expected Outcomes

- Programs and services that are responsive to client needs in the community.
- Ensure people with concurrent disorders have access to services in a system that is committed to a "recovery" focus.
- Promote collaboration among programs and services to recognize and share innovation and creativity.
- Commit to early identification and intervention to improve health outcomes.

Improve the quality of Care at the End-of-Life

Two education and skills enhancement programs will be available to all care providers, including volunteers, and across all disciplines and care settings to enhance palliative care practice in the LHIN. The Southwest Learning Initiative and the Pallium Learning Essential Application in Palliation (LEAP) will be introduced. The Southwest Initiative has been endorsed by the Provincial EOL Network; and the LEAP Program is acknowledged across Canada as a best practice training program. The LEAP program will be run in partnership with the Division of Palliative Care, Department of Family Medicine at McMaster.

Expected Outcomes

- Build competencies among health professionals and volunteer caregivers.
- Create a process of care that guides patient understanding and decision-making.
- Attend to the emotional and spiritual needs of terminally ill patients and their families.
- Preserve the quality of life and dignity of dying patients.

Standards for palliative care assessment, treatment and communication are being implemented this fall. This Provincial Palliative Care Integration Project (PPCIP) will be managed by the Juravinski Cancer Centre and will be launched with the assistance of regional improvement project coordinators, palliative care physician leads and EOL Care Network directors. The initial focus will be on cancer patients; however, the guidelines will be extended to all palliative patients and their caregivers.

Expected Outcomes

- Equitable and timely access to appropriate care.
- Offer patients relief from pain and other symptoms.

- Respect for each patient's values and choices.
- Preserve a patient's quality of life and dignity.
- Assist with difficult decision-making when necessary.
- Reduce unnecessary duplication of services.

Specialized Services for Frail Seniors

The collaborative will include those who use and will use specialized geriatric services, as well as providers, educators, funders, policy makers and researchers. The primary goal is to develop an inter-connected network of specialized geriatric health care services that will promote:

- Strategies for optimizing care and support for frail elderly in the LHIN.
- Equitable access to specialized geriatric services in hospitals and in the community.
- Better connections among services to make it easier for people to get the right service at the right time, consistent with their preferences, and easier for providers to organize and deliver best practice care.
- Advice on the allocation of resources consistent with need and desired outcomes.

Expected Outcomes

Ensure continuous quality improvement through shared expertise and resources by:

- Providing improved ideas and practices of the best way to care for older adults.
- Identifying best practices among existing providers' services in the care of the elderly.
- Shifting other providers' attention to the importance of caring for older adults.
- Promoting equitable access to services levels across the LHIN.

Next steps include strengthening the collaboratives for planning and/or implementation, confirming milestones, and identifying indicators for selected outcome measurement. It is anticipated that the LHIN organization will have variable support roles in one or more of the integration areas, depending on the capacity of the collaborative to move forward.

Enabling Strategies

Integrated information and communication technology was identified in November 2004 in the HNHB LHIN as a key enabler for timely, effective, patient centered care. Subsequently, the Minister of Health and Long-Term Care has indicated that a comprehensive e-Health strategy is a big part of Ontario's plan, and that Ontarians will see the difference that e-Health makes in the quality of care they are receiving. In response to the level of support and readiness to "make this happen", the LHIN has worked with stakeholders to develop a directional document to guide e-Health strategies for an improved health system over the next several years.

Health information is not available to consumers and providers when they need it. People do not have easy access to clear information about care choices and outcomes. Clients and patients repeat their medical history each time they seek/receive care. People undergo the same test multiple times for different providers and physicians do not always receive their patients' hospital discharge summaries. Patient information is not always available to providers to make informed treatment decisions and plan ongoing care. There is limited access to best practice information to guide decisions to improve health outcomes, and the lack of comprehensive service data limits opportunities to make the right improvements.

The Hamilton Niagara Haldimand Brant LHIN has developed a plan to guide communication, information management and technology. The strategies are guided by the LHIN's e-Health vision:

Access to timely, accurate information so that

- People are able to make decisions about their health and wellness.
- Providers have the right information at the right time.
- The health system is managed safely, effectively and efficiently.

People will have the information and support they need to enable them to stay healthy, participate in their care delivery and improve their health care experience. Providers will have the information they need to provide quality patient care and coordinate care across care settings. Managers will have the information they need to operate more efficiently and effectively and planners will have timely and accurate information on population health needs and provider capacity for better decisions.

The HNHB LHIN e-Health Strategic Plan will be used to engage MOHLTC and health service provider partners in detailed discussions on implementation.

Six broad strategies will enable e-Health goals and objectives:

1. Equip and connect stakeholders	• Bring health care providers across our LHIN to a minimum level of computerization and connectivity needed to share information. • Lay the foundation for an electronic health record system accessible to authorized providers across the LHIN.
2. Protect information security and privacy	• Ensure that individual health care providers are reliably identified and authorized to access health information. • Develop appropriate security and privacy mechanisms.
3. Promote knowledge exchange	• Create and sustain an informed and competent stakeholder community. • Engage residents in the health care process and inform them about health provider and health system performance. • Develop tools for knowledge exchange between scientists, care providers, and the academic community across the LHIN.
4. Share clinical information	• Integrate existing systems and deploy new systems to share client, patient and clinical care information amcng authorized providers across the LHIN.
5. Provide decision support systems	• Provide access to comprehensive and reliable information and the right tools to enable effective health system planning, analysis, and performance measurement.
6. Unify information technology resources	• Leverage current information technology resources to improve services and achieve efficiencies through closer collaboration, standardizing processes, strategically purchasing services, and extending support to providers that are currently under-serviced.

- A key role of the LHIN is to encourage and facilitate relationships for solution building, consistent with shared accountability for health outcomes. It will be necessary for the LHIN to create the expectation and mechanisms for networks to align their activities for comprehensive solutions sought. Discussions are underway to develop a framework to guide collaboratives, their ways of work and their accountabilities.

- Consistent with the community engagement principle for inclusiveness, and the role collaboratives can play for health outcomes, the LHIN will continue to model and encourage broad participant inclusion and intersectoral planning and decision making where warranted. Discussions are already underway between McMaster Children's Hospital and Ministry of Community and Youth Services to identify partner opportunities child and youth integration priority directions.

- The LHIN organization will continue to work with champions for the local priorities and develop indicators for local health system monitoring. These initiatives will be integrated with MOHLTC performance measures for an evolving LHIN report card. Senior LHIN Staff are meeting with community support services to identify important measures in the HNHB LHIN, and will assist the Steering Committee for Integration Priorities with their measurement initiatives.

- The HNHB LHIN described its commitment to community engagement in its report, "Our Commitment to You. Community Engagement for Health Planning and Decision Making". The LHIN will continue to work with the Steering Committee for Hamilton Niagara Haldimand Brant LHIN Priorities, local expertise and communities of interest to develop approaches for involving citizens in planning and decision making and evaluation frameworks. In addition, the LHIN will convene thought leaders and community members to advise on the LHIN's longer term strategies for community engagement.

The Ministry of Health and Long-Term Care has identified priority strategies for improved access to care and healthier citizens. This Plan summarizes progress in the HNHB LHIN on selected priorities. These include:

- Access to Care
  - o Access to Primary Care

- Priorities for which the HNHB LHIN is responsible for managing as per the LHIN's accountability agreement, or assessing readiness to work with MOHLTC:
  - o Wait Time Strategy
  - o Diagnostic Imaging
  - o Health Human Resources

- Provincial priorities for which there is a designated lead in the HNHB LHIN:
  - o Critical Care

- HNHB LHIN Initiative on provincial programs:
  - o Laboratory Services

In addition the ministry has signalled the importance of improving access to services for aboriginal and French language populations in Ontario.

Access to Primary Care

The Ministry of Health and Long-Term Care has committed to improving access to primary care, principally through increased numbers of community health centres and the introduction of Family Health Teams in Ontario. Four (4) new Community Health Centres and several Family Health Teams are evolving in the HNHB LHIN. Together, these program initiatives will bring care closer to home in underserved communities for primary health care.

Primary care refers to the patient's first point of contact with a doctor or health care team. Primary care includes but is not limited to disease management and prevention, disease cure, rehabilitation, palliative care and health promotion. Increasingly, evidence suggests that there is a relationship between strong primary health care systems, healthier populations, and effective use of health care resources.

Community Health Centres (CHCs) are not for profit organizations that provide primary health and health promotion programs for individuals, families and communities. CHCs ensure that people who face barriers to care have access to health care and related programs for well being. Barriers include race, language, poverty, disability or geographic isolation, among others. Generally, CHC teams include physicians, nurse practitioners, nurses, counsellors, community workers and dietitians.

There are four community health centres in the Hamilton Niagara Haldimand Brant LHIN serving, in Hamilton, an inner city population, a north end largely immigrant population, and an urban aboriginal population, and in Hamilton and Welland, a diverse French speaking population.

Four Community Health Centres have been announced in the areas of: Fort Erie/Port Colborne, St. Catharines, Niagara Falls, and Brantford. These communities, when compared to Ontario, have lower incomes, higher rates of unemployment and lower education levels; proportionately more seniors living alone and proportionately more single parent families[11].

The LHIN has been approached by the Ontario Association of Community Health Centres to assist with the development of business plans for these new CHCs. The LHIN will provide data and information where feasible, the outcomes of its community engagement processes for planning, and other local intelligence.

A Family Health Team (FHT) is a new model of primary care that brings together different health care providers to coordinate quality care for patients. FHTs generally consist of doctors, nurses, nurse practitioners and other health care professionals including, for example, dietitians, pharmacists, and mental health counsellors. FHTs will look different across the province and within LHINs as they organize around the needs of their rostered populations and adopt different governance models[12].

Family Health Teams are designed to:

- Provide better access to care, closer to home.
- Work as a team to keep people healthy.
- Provide extended hours, and after hours access for advice and care.
- Help patients navigate their way through the health system.

- Provide primary health care, chronic disease management, and self help tools to improve health.
- Use state of the art information technology giving providers access to patient information and test results.

Thirteen (13) FHTs are in different stages of development in the LHIN. Family physicians practicing in FHTs account for approximately 25% of all family physicians/general practitioners in the LHIN. The largest FHT in the Province is the Hamilton Family Health Team, a network of Health Service Organizations (HSOs) and Family Health Network (FHN) primary care models. An early success in its implementation is the availability of a mental health counsellor and nutritionist to all patient populations in the Hamilton Family Health Team (FHT).

Considerable investment is being made in primary care. Community and provider expectations of community health centres and FHTs are that more people will be served more effectively. The inability to increase the number of rostered patients over and above current maxima is a limiting factor to serving more people. The extent to which enhanced access to primary health care, improved chronic disease management and increased uptake of self help practices will, for instance, reduce visits to emergency departments and disease burden over time will be monitored in the LHIN.

Niagara	44
Beamsville Medical Centre Family Health Network	7
Garden City FHT, St. Catharines	7
Niagara Medical Group FHT, Niagara Falls	9
Smithville Family Medical Centre FHT	7
Portage Medical Group, Niagara Falls	4
Niagara-on-the-Lake FHT	10
Hamilton	138
Hamilton Family Health Team** • Core Care FHT • Escarpment FHT • Hamilton Downtown Medical Centre • Hamilton Community Health Centre (HCHC) • Innovations Family Medicine FHT • Intramed FHT • Ottawa-Main Medical Associates • Rosedale Medical Group • Stoney Creek and Hamilton Mountain	112 17 17 2 7 22 18 3 6 20
McMaster Family Health Team	26
Brant County, Brantford and Six Nations	7
Six Nations Health Services, Ohsweken	2
Primary Care Community Family Health Team, Paris	5
Haldimand and Norfolk	8
Delhi FHT	5
Haldimand County FHT, Hagersville and Dunnville	3
Burlington	7
Burlington FHT	4
Caroline Medical Group FHT	3

* *Number of physicians, regardless of number of hours worked. Not FTEs*

** *Hamilton FHT is a Network of Family Health Teams with a shared governance model*

Wait Time Strategy

Considerable progress is being made in the HNHB LHIN to reduce wait times for MOHLTC priority procedures. A Wait Time Strategy Steering Committee, co-chaired by hospital and community leaders in the LHIN, is a forum for collaboration to develop action plans to improve access to services, increase efficiency and produce quality outcomes.

The Ontario Wait Time Strategy is a plan to improve access to care and reduce wait times for five major health services: cancer surgery, cardiac procedures (angiography, angioplasty, bypass surgery), cataract surgery, hip and knee replacements and diagnostic scans (MRI and CT exams). Overall, the strategy is designed to:

- Increase the number of procedures in order to reduce the backlog that has developed over the last decade.
- Invest in new, more efficient technology such as MRI machines and extending hours of operations.
- Standardize best practices for both medical and administrative functions in order to improve patient flow and efficiency.
- Collect and report accurate and up-to-date data on wait times to allow better decision making and increase accountability.

Ontario's access targets were developed after consultation with clinical experts from across Ontario. They reflect a new priority system to better and more consistently manage access to services based on the urgency of need for treatment. The access target is defined as the wait time by which 90% of cases will have completed their surgery or exam (MRI or CT) from the time the decision was made by the specialist to proceed with surgery or exam.

1	Immediate	Immediate	Immediate	Immediate	Immediate
2	6 weeks	6 weeks	48 hours	2 weeks	2 weeks
3	12 weeks	12 weeks	2-10 days	4 weeks	6 weeks
4	26 weeks	26 weeks	4 weeks	12 weeks	26 weeks

In the HNHB LHIN, the access target is being achieved for cancer surgeries and cardiac procedures (angiography, angioplasty, and bypass surgery) and not yet in the service areas of hip and knee replacements, cataract surgery, MRI and CT scans, on data reported for June July 2006.

An unintended consequence of the wait time strategy is the degree to which people in the community may be waiting for in-home care and support requirements, as CCAC resources are directed to post-hospital recovery for priority patients. This trend will be monitored and the level of population risk assessed.

Diagnostic Imaging (MRI/CT)

Magnetic Resonance Imaging (MRI) and Computed Tomography (CT) are tools for the diagnosis, treatment and follow-up of illness. In April 2005, the MRI and CT Expert Panel submitted its interim report to the Minister. The report presents a plan that provides Ontarians with improved access to MRIs and CTs in a timely and appropriate manner.

Dr. Julian Dobranowski, Chief Radiologist at St. Joseph's Health Care Hamilton, was a member of the Expert Panel and is the MRI/CT lead for the HNHB LHIN. Dr. Dobranowski will be working with hospital partners to meet the Panel recommendations for greater standardization, improved efficiencies and clear accountabilities in the delivery of diagnostic imaging services within the LHIN. Elements of the MRI/CT plan include:

- Creation of population-based benchmarks for the number of MRI and CT scans to measure access to imaging services.
- Shared patient diagnostic imaging information to facilitate quicker diagnosis and treatment, e.g. PACS (Picture Archive and Communication System).
- Health human resources plan to meet the growing demand for MRI and CT services.
- Creation of standards to guide decisions about the type of MRI and CT scanners that hospitals need based on their size and level of care they provide.
- Criteria to guide decisions about locating scanners based upon patient safety, availability of trained staff and economies of scale to maximize operational efficiency, and
- Diagnostic imaging networks across the Province to maximise the use of diagnostic expertise and resources within and between LHINs.

Health Human Resources

Attracting and sustaining a high performing and satisfied work force in Ontario's health system is a principal MOHLTC goal. HealthForceOntario is Ontario's innovative, multi-year plan to ensure that the right number and mix of appropriate educated professionals are available now and in the future to meet the needs of Ontarians[13]. The initiative is a partnership of the Ministry of Health and Long-Term Care and the Ministry of Training, Colleges and Universities and is responsible for developing strategies in response to new expectations, required capacities and evolving provider roles.

HealthForceOntario's "Tomorrow in Ontario" profile is providing the context for local, regional, provincial and multi-sector initiatives for health human resources planning.

People will	Health Services will	Health service providers will
• be more numerous and older	• be increasingly based in the community setting	• be older and seeking career transition retirement
• be more culturally diverse	• be delivered by interprofessional teams	• continue to come from a range of other nations
• have more chronic than acute illness	• focus on health promotion and disease prevention	• want more balance and flexibility in their careers
• be increasingly involved, informed consumers	• make greater use of new technology including tele-medecine, robotics and genetics/proteomics	• work in a mobile, international and opportunity-laden market
• seek complementary and alternative care		• demand healthy and stimulating workplaces
• focus on wellness and disease prevention		• need new educational models to deal with a rapidly evolving base of knowledge and technology

Source: HealthForceOntario, September 2006

The LHIN convened a health human resources (HHR) forum in September 2006 to explore issues and identify potential local strategies with a focus on HHR requirements to respond to the growing and evolving health care needs of our aging population. Forum participants developed a vision to guide future planning and deliberation:

A health care system with sufficient capacity in human and other resources

- To optimize timely access to appropriate care.
- To promote healthy lifestyles and illness prevention.
- To better coordinate and integrate information and access to health services, for seniors in particular.
- To enable more seamless transitions between care settings.

Next steps will focus on priority areas for HHR planning – those for which there is high readiness and alignment among stakeholders and already identified opportunities, for example, e-Health solutions, collaborative HHR planning among LHIN hospitals, coordinated HHR recruitment and retention strategies among provider groups, and MOHLTC directions.

One feature common to all stakeholders is the training, recruitment and retention of skilled health professionals, including physicians. The HNHB LHIN has one of the lowest physician to population ratios in the province[14]. The Distributive Campus initiative, DeGroote School of Medicine, McMaster University is a response to this issue.

In February 2006, the Government of Ontario announced the implementation of a 15% increase (104 positions) in medical school enrolment over the next 4 years. Of these new positions, 62 will be allocated to the establishment of 4 medical education campuses and affiliated with established medical schools.

Kitchener/ Waterloo	McMaster University	14	15
St. Catharines	McMaster University	14	15
Mississauga	University of Toronto	20	30
Windsor	University of Western Ontario	14	24
Total		62	84

1/ Total seats – additional seats supplemented through the schools' current allocation

Three Implementation Committees (one for each affiliated medical school) have been struck for collaborative planning and problem solving for the medical schools, affected communities and the government. There are representatives from the Ministry of Health and Long-Term Care (Health Human Resources Branch, Capital Planning Branch and the Health Reform Implementation Team) and the Ministry of Training, Colleges and Universities.

The development of the regional medical campuses serving Niagara and the Waterloo Wellington area in an adjoining LHIN represents an opportunity for McMaster University and community partners to provide a strong, distributed learning network. There are many benefits to the community, including physician recruitment. The academic environment offers improved job satisfaction for physicians and other health care professions. Graduates of the program, physician teachers and physicians seeking to work in a teaching environment may be attracted to the community and they can continually update clinical and teaching skills. There are also opportunities for participation in research and to attract research funds.

Critical Care

Critical care is the specialized care of patients whose conditions are life-threatening and who require comprehensive care and constant monitoring, usually in intensive care units. The MOHLTC Critical Care Strategy, designed to improve access, quality and system integration, comprises seven closely linked initiatives:

- Critical Care Response Teams
- Critical Care Capacity
- Health Human Resources
- System-Level Training
- Critical Care Information System
- Performance Improvement Collaborative
- Ethical Issues of Access

Dr. Peter Kraus, Chief of Critical Care Medicine at Hamilton Health Sciences, is the appointed Critical Care Lead for the HNHB LHIN. Regular meetings of Critical Care LHIN leaders are scheduled to discuss opportunities for improving service delivery. Local work under way is building on provincial initiatives.

- The Provincial Inventory of Critical Care Resources report will be available on the Critical Care Strategy website in October 2006. The inventory will provide the data required for the creation of the Critical Care Information System.

- Beginning in 2006/07, $4.5 million will be available to Ontario hospitals annually to help cover the costs of training more critical care nurses. At the same time, new standards for critical care nurse education will be released along with the Final Report of the Critical Care Nursing Standards Task Group.

- Performance improvement coaching teams are now engaged in 16 Ontario hospital sites. In August 2006, Hamilton Health Sciences Centre (Henderson site), Brant Community Health Care System and Norfolk General Hospital had site visits.

In addition, the current Critical Care Response Teams (CCRT) at St. Joseph's Health Care, Hamilton General Hospital and McMaster's Children's Hospital comprise 3 of 22 provincial demonstration projects due to go live on November 6, 2006. The CCRT concept is designed to enhance staff collaboration and information sharing to promote more timely intensive care unit (ICU) admissions that result in shorter length of stay, and prevent inappropriate ICU admissions or re-admissions. Additional multi-site demonstrations involving small hospitals will explore alternate CCRT models that meet the needs and capabilities of hospitals that care for critically ill patients but do not have "level 3 ICUs".

Laboratory Reform

Laboratory testing affects approximately 70% of all medical decisions. Accurate and timely test results are necessary for determining treatment decisions and health outcomes. Laboratory reform is underway across Ontario and is making progress in the HNHB LHIN. Laboratory reform goals include:

- Real time sharing of results for patient centered care and reduced duplication of tests.
- Unified public and private systems for standard practice and information sharing.
- Improved accountability for the range and number of tests and quality outcomes.
- System wide capacity planning for sustainable laboratory and evidence based tools and practice.

The Regional Laboratory Steering Group for the HNHB LHIN is made up of lab chiefs, pathologists, and hospital administrators, among others. The Steering Group is enabled by a Memorandum of Understanding among 12 hospitals in the LHIN that lays the groundwork for shared initiatives. The group is committed to increasing momentum on identified priorities.

Nine priorities have been identified for a sustainable lab system in the LHIN.

Information Technology	Share information seamlessly among organizations
Governance	Define a structure or alliance agreement to guide future collaboration
Human Resources	Consolidate an HRR strategy for recruitment, retention and training*
Consolidation of Services	Create Centres of Excellence for selected procedures/tests
Quality	Implement common CQI
Cost Efficiency/Utilization	Improve efficiencies through for example centralized purchasing**, affordable specimen transportation
Clinical Program Support	Implement common patient identifier
Specialized Testing	Centralize specialized test e.g. transfusion medicine
Standardization	Implement common work load measurement and reporting

explore collaboration with LHIN Human Resource Work Team

**explore collaboration with LHIN Integrated Supply Chain Management Group*

The Steering Committee has recommended to the HNHB Hospital CEO Group that actionable strategies should be developed by March 2007 for IT and Governance priorities. Next steps include linking the IT requirements for sharing lab tests with the e-Health Strategic Plan, and laboratory rationalization to any clinical program realignments.

Special Populations

Consistent with provincial and federal legislation, the Local Health System Integration Act signals the importance of both the French language (FL) and Aboriginal communities in Ontario, and the requirements of LHINs have to specifically work together with these communities to improve access to services and health outcomes[15].

French Language Population in the LHIN

Almost 2.5% of the population in the HNHB LHIN is Francophone. Both Hamilton and Niagara are designated communities for French language services, as more than 5,000 people in each area identify French as their mother tongue.

LHIN leadership met with French language providers in the LHIN, attended a joint board meeting of the Centre de Santé Communautaire and Foyer Richelieu (Long-Term Care home), and co-sponsored a roundtable with the Centre. The goal has been to listen and learn about the FL community and begin to work together.

The LHIN will promote quality FL services for best outcomes and acknowledge and respect diversity within the FL communities. FL residents and stakeholders know their communities best; the LHIN's planning and coordination activities will build on existing

FL planning and coordination for FL health services. The LHIN will work with indigenous leaders to facilitate access to hard to reach populations for planning and decision making.

Aboriginal Populations in the LHIN

There are two reserves in the LHIN: Six Nations of the Grand River Territory and Mississaugas of the New Credit First Nation. Approximately half of the identified aboriginal population residing in the LHIN area live On-reserve.

As of August 2006 the total registered Aboriginal population living On or Off-reserve in the LHIN was 24,263, 1.7% of the total LHIN population[16] . However, the inability to precisely measure population numbers underestimates the true population and has implications for service planning.

The LHIN organization was invited by Six Nations to host an open house in September. The community is willing to be involved with the LHIN to plan and manage their health care needs, and managing their resources. Their goal is affordable and accessible services for all community members, especially for people with complex health conditions, and isolated persons. Access to both traditional and western medicine is a high priority. Preference is for native doctors and health practitioners working in native communities – both On and Off-reserve. Quality services are important. The relationship between practitioner/caregiver and client is essential; people want adequate time with their practitioners, they want to be respected, and their privacy needs to be honoured.

The community wants to increase the knowledge and awareness of healthy lifestyles for health and well-being, and proposes that health promotion activities be developed and strengthened for school children, and that recreation facilities be expanded.

As importantly, the LHIN's own education should focus on diversity among Aboriginal peoples, the health resources and constraints governed by federal and provincial jurisdictions, the circumstances that can contribute to poorer health among aboriginal peoples e.g. poverty, housing, transportation, isolation and the tremendous local community assets that can be brought to bear on community well-being goals and strategies.

Patient Flow

Alternate Level of Care (ALC) days in hospitals are rising in the HNHB LHIN. The inability of hospitals to discharge patients to the most appropriate care e.g. long-term care, chronic care, slow paced rehab, and back home with supports following inpatient services has increased significantly since June. The consequences include emergency room overflow in hospitals and cancelled elective surgeries. The inability to move patients through the health system to the most appropriate setting signals the need for a LHIN wide approach to leverage all resource opportunities in hospitals, CCACs, long-term care homes, and retirement homes, supportive housing, community support services, and transportation programs for early and long term solutions.

Coordinated Chronic Disease Management Strategies

There is considerable commitment among family health teams, public health units and community health centres to introduce and strengthen chronic disease management strategies. Chronic conditions are leading causes of illness, disability and poor quality of life generating a significant burden for individuals and their families, the work force, the health system and communities[17].

The LHIN does not have funding and performance monitoring responsibility for public health and primary care family health teams, however, it is in the public interest to reduce the burden of illness, align strategies and resources for health gain overall in the LHIN and collaborate for shared outcomes.

Obstetrics

It is estimated that the number of women of child bearing age will fall by 2% by 2016; there are potential pockets of growth, for instance, in the Norfolk Simcoe area where a new Toyota plant will bring more than 2000 new jobs. There are questions emerging as to the best ways to sustain high quality obstetrics care and recommended best practices in the face of this changing demographic, an aging nursing workforce, inadequate physician supply for comprehensive 24/7 on call coverage, and other health professional supply, e.g. anaesthetists, perinatologists. A LHIN wide system approach to appropriate capacity and distribution of services is required to inform program design options, scope of practice, recruitment strategies, and infrastructure planning, with the goal in mind of quality care for maternal child health.

Other Priorities

Hospitals in the LHIN have identified several priorities for integration, including laboratory reform, human resources planning, e-Health strategy, and establishing centres of excellence. The hospitals will move their priorities forward with facilitation by the LHIN when required to assist with addressing barriers to progress.

Comprehensive transportation planning and coordination to support access to health services is not within the LHIN's mandate. MOHLTC funds do support volunteer-assisted programs in the community support services program sector; responsibility for land ambulance services lies with municipalities. However, access to health services is consistently one of three top concerns in all communities in the LHIN, both rural and urban. Lack of affordable, efficient and integrated non-urgent transportation is a barrier to accessing health services either close to home or in another community. In addition, inability of hospitals to transfer patients back home or to long-term care homes reduces access to beds. The LHIN will continue to encourage the inclusion of transportation stakeholders in all health services planning.

Finally, there is considerable interest in measuring integration and the available tools and processes to both guide and measure how new ways of work are/will be making a difference for an available, accessible and acceptable health system.

Setting the Stage: Achievements in the LHIN

There is considerable progress among stakeholders in the Hamilton Niagara Haldimand Brant LHIN for enhanced collaborative planning and problem solving. The transformation agenda and the presence of the LHIN have in and of themselves stimulated new relationships, refocused planning and coordination efforts, and strengthened commitment to both local and MOHLTC priorities.

- Community Support Services (CSS)[17] have for almost a year now been meeting collaboratively at the LHIN level, exchanging ideas about planning and service challenges, and opportunities and solutions that can be leveraged jointly. These include volunteer and professional learning and development, strategies to address local priorities, and dialogue with the LHIN organization.

- Acquired Brain Injury Services in the LHIN met jointly for the first time in September 2006. The opportunity and responsibility for ensuring access to services in the LHIN and sharing best practice have to some degree signaled "permission" to communicate and cooperate for patient outcomes.

- The Niagara Region Inter-agency Transportation Network[18] has made recommendations to improve the capacity, coordination and efficiency of specialized and volunteer transportation services by means of, for example, consolidated intake and consistent operating procedures. This is a significant breakthrough for a multi-sectoral group addressing a key enabler for access to health and related services.

- A Memorandum of Understanding among the hospital CEOs in the HNHB LHIN is strengthening joint planning, prioritizing and problem solving. The Hospital CEOs committed early to an Integrated VP for Information and Communication Technology in the LHIN. The subsequent role the VP played in the development of an e-Health Strategic Plan for all health service providers in the LHIN signals the hospitals' strong commitment to system wide solutions.

  - Several collaborative working groups reporting to the CEO group meet to align business practices. These include Health Human Resources, Finance, Communications, Lab, Diagnostic Imaging, Pharmacy, IT, Chiefs of Staff, and Decision Support.

  - The HNHB LHIN hospitals have been early and eager participants in the Perioperative Coaching Team initiative. Joseph Brant Hospital and Brant Community Healthcare System were two of the first hospitals to have a coaching team visit in Jan-Feb 2006. Since that time, four additional hospitals within the LHIN, Norfolk General, West Lincoln Memorial, the Niagara Health System and St. Joseph's Healthcare have also had coaching team visits. West Haldimand Memorial Hospital and Hamilton Health Sciences are scheduled for coaching visits in early 2007. The action planning issues and strategies developed at each of these coaching team visits have been shared across the LHIN at the Perioperative Director Committee level, as well as the VP of Clinical Services Committee to provide an opportunity for shared learning in best practice.

  - Two Hamilton based projects to address wait time strategies are being expanded to encompass the broader LHIN – the Joint Arthroplasty Assessment Centre and the Cataract Surgery Centre of Excellence.

- The Mental Health Rights Coalition (MHRC) in Hamilton is currently working with service providers in the Hamilton area on a pilot project to integrate peer support workers into community mental health agencies, with a goal to enhance and expand this model across the LHIN as resources permit. This follows on the recommendations of the Central South Mental Health Implementation Task Force[20] which recommended an "increase in the range and number of consumer roles in order to place consumers at the centre of the mental health system and operationalize the recovery-based philosophy." The MHRC is well placed to share the pilot experience and outcomes: the organization is a member of the Central South Mental Health and Addiction Network, and links the consumer/survivor initiatives with mental health and addiction service providers across the LHIN.

- With respect to inter-LHIN collaboration, a review of Vascular Surgery in the Hamilton Niagara Haldimand Brant and the Waterloo Wellington LHINs was done to assist the hospitals in the two LHINs to develop a plan for vascular surgery services in the region that will provide for an effective and efficient response to the populations' needs for both elective and unscheduled vascular surgery services. The report recommends a regional program that spans both LHINs with the Regional Centre located in Hamilton, and calls for a) an integration of services between Hamilton Health Sciences and St. Joseph's Healthcare; and b) the creation of two Associate Centres, one at the Niagara Health System, St. Catharines site and one either at the Guelph General Hospital or Grand River Hospital. The recommendations have been supported by the leadership of the hospitals and a steering committee has been working to develop a plan and to implement the recommendations.

- The Central South Infection Control Network provides a coordinated approach to infection prevention and control across the continuum of care. This Network in the HNHB LHIN has provided education related to provincial guidelines for stakeholders and has held focus groups to assist with interpretation and best practice. Outcomes have been used to refine the original guidelines and have contributed significantly to the development of ICNs across the Province.

HNHB Current Activities 2006/2007

The Hamilton Niagara Haldimand Brant activities over the next few months are shaped by what we have learned from our communities. Shared responsibility among health service providers for health system outcomes is generally supported, yet is not fully understood and is daunting for many. Commitment and goodwill for a sustainable health system need to be complemented with skills and tools to support new ways of work to meet new expectations. The self-identified challenges for health service provider boards and executive leadership include: inexperience with collaborative problem solving and decision making, lack of information and data, little understanding as to who is doing what and why, inability to deal with competing interests, and little or no flexibility for creativity.

In addition, the word "integration", central to the health transformation agenda, means different things to different people. Similarly, "care close to home" or "as close to home as possible" elicits different expectations among citizens, stakeholders and providers. Considerable discussion on these constructs, what they mean, and how they can inform an approach to planning and coordination is important.

Processes and tools for priority setting and decision making and that promote the alignment of activities among stakeholders and providers for specified outcomes are key. The LHIN organization will develop with others tools and frameworks that can be used to guide planning and decision making, and define criteria for success.

The focus of current activities through to March 2007 is threefold:

- Continuing to understand the present state of health care in the HNHB LHIN;
- Moving forward on priorities and ideas from Year 1 planning to transform elements into tangible solutions for health system improvement; and
- Developing processes to support health service providers' shared responsibility and accountability, and decision making tools for prioritization and funding.

Over the next few months, LHIN stakeholders and communities of interest will report on progress to date on initial integration strategies, identify health improvement solutions on emerging priorities, and confirm opportunities for improvement at the local level based on environmental scan outcomes, the emerging MOHLTC directions, and the outcomes of various Provincial panel deliberations. The convergence of these activities will enable the LHIN to consult with citizens, stakeholders and providers on proposed Phase 2 Integration Health Service Plan directions in Spring 2007 and confirm directions by June 2007. These outcomes will guide coordination and funding decisions for the 2008-2009 year.

Above all, the Hamilton Niagara Haldimand Brant LHIN will continue to:

- Recognize and support change in the current climate.
- Mobilize stakeholders and LHIN Staff to work on identified elements for capacity building.
- Work with the Ministry of Health and Long-Term Care as it develops its strategic health plan.
- Verify levels of consensus and commitment on improvement strategies and solutions.
- Promote and support ongoing collaboration and partnership efforts to implement change strategies.
- Ensure that improvement initiatives are based on evidence/best practices, that they can be evaluated and that they are scalable where possible.

1. Assessing Present State								
ENVIRONMENTAL SCAN								Feasible health system improvement solutions
• Assess existing health sytem design recommendations								
• Consult and validate findings								
EMERGING PRIORITIES*								Best practice recommendations for patient flow, obstetrics, co-ordinated chronic disease management strategy
• Assess current state								
• Identify improvement options								
•Consult and validate								
HNHB LHIN PROFILE								Health System Fact Book for LHIN wide reference and agenda setting
• Health system fact book								
2. Capacity Building								
EARLY INTEGRATION PRIORITIES								Enhanced stakeholder leadership for health system improvement
• Assess requirements for planning and implementation								
• Facilitate approaches for								
-Milestone monitoring								
-Indicator development								
-Knowledge Transfer								
e-HEALTH STRATEGY PHASE 2								3-year business plan for e-Health implementation
• Consultation on e-Health Strategy								
• Implement e-Health Strategy								
• Establish governance structure								
• Prioritize strategies								
NETWORKS IN THE LHIN								Guide for collaboratives: ways of work, accountabilities, and LHIN alignment
• Develop framework for role of networks								
• Consult and validate								
COMMUNITY ENGAGEMENT								HNHB LHIN CE Framework & Evaluation
• Collaborative governance								
-Education Plan for shared responsibility and accountability								
• Engaging discussion on integration								
-Definitions, approaches, measures, and resources								
• Engage and learn from the community								
-Develop CE strategies, cycles, evaluation approaches, and ethical engagement tools								
3. Planning and Decision Making								
PRIORITY SETTING								HNHB decision-making framework
• Funding and allocation								
• Integration measures								
• Consult and validate								

[1]Local Health System Integration Act. Bill 36. March 2006

[2]Chapter 4. Local Health System Integration Act. March 2006. Available at www.e-laws.gov.on.ca/DBLaws/Statutes/English/06104_e.htm

[3]Ministry of Health and Long-Term Care (2004a). Taking Action To Improve Health Care. Available at www.health.gov.on.ca/transformation

[4]Ministry of Health and Long Term Care (2005). Local Health Integration Networks. Bulletin 11. May 2. www.health.gov.on.ca/transformation

[5]Ministry of Health and Long-Term Care. Roadmap to the Integrated Health Service Plan. January 2006

[6]Report of the LHIN 4 Steering Committee for Integration Priorities. Hamilton District Health Council. February 2005

[7]Community Visions. Community Solutions: Grantmaking for Comprehensive Impact. Joseph A. Connor and Stephanie Kadel-Taras. Wilder Publishing Centre. Minnesota. 2003. page 66

[8]Governance Consultation Session. Hamilton Niagara Haldimand Brant LHIN. September 2006

[9]Physician to population ratio represents population per active physician; physician counts include active general practitioners and family practitioners as of Dec 1, 2004. Canadian Institute for Health Information. Scott's Medical Database.

[10]A Framework for the Relationship Between Academic Health Science Centres and Local Health Integration Networks in Ontario. Council of Academic Hospitals in Ontario. May 31, 2005.

[11] Statistics Canada 2001

[12] Family Health Teams may establish themselves using one of three governance models: community based, provider based or a mix of community and provider based.

[13] HealthForceOntario. Presentation by Josh Tepper, Ministry of Health and Long-Term Care, to Ontario LHIN CEOs. September 2006.

[14] Hamilton's physician to population ratio in 2004 was 84:100,000.

[15] The Canadian Multiculturalism Act (1970) enshrined Canadian policy to encourage and assist the social, cultural economic and political institutions in Canada to be both respectful and inclusive of Canada's multicultural character. The Canadian Human Rights Act (1981) states that all individuals in Canada should have equal opportunity and their needs accommodated (within the law). The Canadian Charter of Rights and freedoms guarantees equality rights (Section 15), equal rights (Section 26) and directs Canadians to value, preserve and maintain cultural diversity in the exercise of their rights and freedoms (Section 27). In. Ontario, the French Language Services Act guarantees individuals the right to receive services to the public provided by a Ministry or an agency of the government in French, in twenty-four designated areas, including Hamilton

[16] Resources for Aboriginal Health Planning. Intergovernmental and Aboriginal Policy Branch. Ontario Ministry of Health and Long-Term Care. July 2006

[17] Chronic Conditions in Hamilton. A Time for Dialogue A Need for Action. Hamilton District Health Council. September 2004. www.dhcarchives.com

[18] Community support services: services provided to persons who because of disability, age or frailty require assistance with daily living. They include for example, transportation, friendly visiting, respite, meals.

[19] Volunteer Transportation Study for the Region of Niagara. Niagara Inter-Agency Transportation Network. January 2006.

[20] Making Recovery Happen. A Report of the Central South Mental Health Implementation Task Force. December 2002

Hamilton Niagara Haldimand Brant
LOCAL HEALTH INTEGRATION NETWORK

RESEAU LOCAL D'INTEGRATION DES SERVICES DE SANTE
de Hamilton Niagara Haldimand Brant

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